

Case Number:	CM15-0003791		
Date Assigned:	01/14/2015	Date of Injury:	11/04/1996
Decision Date:	03/24/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	01/08/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 53-year-old female who reported an injury on 11/04/1996. The mechanism of injury was not submitted for review. Past medical treatment consists of lumbar laminectomy, lumbar fusion, spinal cord stimulator, trigger point injections, therapy, and medication therapy. Medications include Mobic, Lexapro, Ambien, Flexeril, Tylenol with Codeine and Norco. No UAs or drug screens are submitted for review. On 11/18/2014, the injured worker was seen for a follow-up where she complained of low back pain which was mostly right sided. The injured worker rated the pain at a 9/10 without medications and a 6/10 with medications. Physical examination revealed that there was tenderness in the right lumbosacral area. Active voluntary range of motion was guarded in forward flexion and 10 degrees in extension with complaints of back pain with extremes of motion. The motor and sensory examination of the lower extremities was normal. Deep tendon reflexes were 1 to 2+ bilateral infrapatellar and 0 to 1+ bilateral Achilles and symmetrical. Medical treatment plan is for the injured worker to continue with medication therapy. Rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Norco 10/325mg # 120 refills x 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-97.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ongoing management, Opioids, dosing Page(s): 60; 78; 86.

Decision rationale: The request for Norco 10/325 with a quantity of 120 and 2 refills is not medically necessary. California MTUS Guidelines recommend opiates for chronic pain. They suggest and note that there should be documentation of an objective improvement in function, and objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The cumulative dosing of all opiates should not exceed 120 mg oral morphine equivalents per day. The submitted documentation did not indicate the efficacy of the medication, nor did it indicate that it was helping with any functional deficits the injured worker was having. Additionally, there were no assessments submitted for review indicating what pain levels were before, during, and after medication administration. Furthermore, there were no UAs or drug screens submitted for review showing that the injured worker was compliant with prescription medications. Given the above, the request would not be indicated and the injured worker is not within California MTUS recommended guideline criteria. As such, the request is not medically necessary.